TEXT OF REGULATIONS

Subarticle 2: Risk-Bearing Organizations

DRAFT - FOR DISCUSSION PURPOSES ONLY
January 5, 2001

TEXT OF PROPOSED CHANGES
TO THE REGULATIONS UNDER THE
KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975

1. Adopt Subarticle 2 (commencing with Section 1300.75.4) to Article 9 of Subchapter 5.5 of Chapter 3 of Title 10, California Code of Regulations, to read:

Subarticle 2: Risk-Bearing Organizations

1300.75.4. Definitions.

(a) As used in this subarticle:

(1) "External party" means the Department of Managed Health Care or its designated agent, which may be an outside entity or person contracted or appointed to fulfill the functions stated in these regulations. Whenever these regulations reference the Department of Managed Health Care, that reference means the Department of Managed Health Care or its designated agent, which may be an outside entity or person contracted by the Department of Managed Health Care to fulfill the stated function.

(2) "Organization" means a risk-bearing organization as defined in subdivision (g) of Section 1375.4 of the Code.

(3) “Risk arrangement” shall include both “risk-sharing arrangement” and “risk-shifting arrangement,” which are defined as follows:

(A) "Risk-sharing arrangement" means any compensation arrangement between an organization and a plan under which both the organization and the plan share a risk of financial loss.

(B) “Risk-shifting arrangement” means a contractual arrangement between an

organization and a plan under which the plan pays the organization on a fixed, periodic or capitated basis, and the financial risk ~~of~~ for the cost of services provided pursuant to the arrangement is assumed by the organization.

(b) For purposes of subdivision (g) of Section 1375.4, the term "lawfully organized group of physicians" means a medical group, independent practice association, or other entity that delivers, furnishes, or otherwise arranges or provides health care services, but excluding an individual or plan, and excluding any entity barred from the practice of medicine by California Business & Professions Code Section 2400 or a successor provision to California Business & Professions Code Section 2400.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

1300.75.4.1. Risk Arrangement Disclosure.

(a) Every contract involving a risk arrangement between a plan and an organization shall require the plan to do all of the following:

(1) Disclose through electronic transmission ~~in writing~~ (or in writing, ~~through electronic transmission~~, if agreeable to both the organization and the plan) to the organization, on a monthly basis, beginning with the month of May, ~~April~~, 2001, within 10 calendar days of the ~~end~~ beginning of each report month, the following information for each enrollee assigned to the organization: member identification number, name, birth date, gender, address, ~~zip code of residence,~~ plan contract selected, any other third party coverage, if known to the health plan, enrollment/disenrollment dates, medical group/IPA number, provider effective date, type of change to coverage, co-payment, deductible, the amount of capitation to be paid per enrollee per

month, and the primary care physician when the selection of a primary care physician is required by the plan ~~or identified to the plan~~.

(2) Disclose through electronic transmission ~~in writing~~ (or in writing, ~~through electronic transmission~~, if agreeable to both the organization and the plan) to the organization, on a monthly basis, beginning with the month of May, ~~April~~, 2001, within 10 calendar days of the beginning ~~end~~ of each report month, the names, member identification numbers, and total numbers of enrollees added or terminated under each plan contract served by the organization.

3) Disclose, as part of the contract with the organization, for the purpose of assisting the organization to be informed regarding the financial risk assumed under the contract, the following information for each and every type of risk arrangement (Medicare+Choice, Medi-Cal, traditional commercial, Point of Service, small group, and individual plans) under the contract:

~~(A) The nature of the risk arrangement; the purpose of the risk arrangement; and the time period for the risk-sharing arrangement;~~

(A ~~B~~) ~~Identification through~~ a matrix of responsibility ~~of the medical expense categories~~ for medical expenses (physician, institutional, ancillary, and pharmacy) which will be allocated to the organization, facility, or the plan ~~the hospital and the enrollee~~ under the risk arrangement; ~~the source of the data and the actuarial methods employed in determining the rates by benefit plan type, including the utilization and unit cost actuarial assumptions by expense category used to determine the reimbursement to the organization for the risk arrangement;~~

(B) expected/projected utilization rates and unit costs for each major expense service group (inpatient, outpatient, primary care physician, specialist, pharmacy, home health, durable medical equipment (DME), ambulance and other), the source of the data and the

actuarial methods employed in determining the utilization rates and unit costs by benefit plan type for the type of risk arrangement; and

(C) all ~~F~~factors used ~~for any adjustments from the actuarial assumptions, factors for point of service out of network service utilization, and any applied age/sex or geographic factors; and~~ to adjust payments or risk-sharing targets for the following: age, sex, localized geographic area, family size, experience rated, and benefit plan design, including but not necessarily limited to copayment/deductible levels.

~~(D) For any risk-sharing arrangements, the actuarial assumptions of utilization and unit cost of service along with any factors such as age/sex.~~

(4) Disclose through electronic transmission ~~in writing~~ (or in writing, ~~through electronic transmission~~, if agreeable to both the organization and the plan) to the organization, on a quarterly basis, within 120 calendar days of the close of each quarter, a detailed description of each and every amount (including expenses and income) allocated to the organization and to the plan under each and every risk-sharing arrangement.

(5) Provide payments of all risk arrangements, excluding capitation, no later than 180 days after the close of the organization's contract year, or the contract termination date, whichever occurs first.

(b) In addition to the disclosures required by subsection (a) of this rule, every contract involving a risk-sharing arrangement between a plan and an organization shall require the plan to disclose, as part of the contract, the amount of payment for each and every service to be provided under the contract, including any fee schedules or other factors or units used in determining the fees for each and every service. ~~and, in the case of capitated payment, the amount to be paid per~~

~~enrollee per month.~~ To the extent that reimbursement is made pursuant to a specified fee schedule, the contract may incorporate that fee schedule by reference, including the year of the schedule. For any proprietary fee schedule, the contract must include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.

(c) In addition to the disclosures required by subsection (a) of this rule, every contract involving a risk-shifting arrangement between a plan and an organization shall require the plan to disclose, as part of the contract, in the case of capitated payment, the amount to be paid per enrollee per month. For any deductions which the plan may take from any capitation payment, details sufficient to allow the organization to verify the accuracy and appropriateness of the deduction ~~regarding each deduction~~ shall be provided.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

1300.75.4.2. Organization Information.

Every contract involving a risk arrangement between a plan and an organization shall require the organization to do all of the following:

(a) For each quarter ~~B~~beginning on or after January 1, ~~with the first quarter of the~~ 2001, ~~calendar year~~ (for an organization that begins its fiscal quarter on January 1, 2001, the first submission is due by May 15, 2001), submit to the Department of Managed Health Care or its designated agent, in a form and manner determined by the Department, not more than forty-five (45) days after the close of each quarter of the fiscal year, a quarterly status report containing all of the following:

(1) Financial statements (including at least a balance sheet, an income statement, and

a statement of cash flows~~, and footnote disclosures~~), or comparable financial statements in the case of a nonprofit entity, for the immediately preceding quarter prepared in accordance with generally accepted accounting principles (GAAP).

(2) A statement as to what percentage of claims ~~received during that quarter~~ have been reimbursed, contested, or denied during that quarter by the organization within 45 working days, and in accordance with the ~~timeframes and~~ other requirements ~~described in~~ of California Health and Safety Code Sections 1371 and 1371.35, and in accordance-with any other applicable state and federal laws and regulations. If less than 95% of all claims ~~received during the quarter~~ have been reimbursed, contested or denied on a timely basis, the statement shall be accompanied by a report that describes the reasons why the claims-paying process is not meeting the requirements of applicable law, any action taken to correct the deficiency, and any results of that action.

(3) A statement as to whether or not the organization has estimated and documented, on a monthly basis, its liability for incurred but not reported (IBNR) claims ~~received during the quarter~~, pursuant to a method specified in Rule 1300.77.2, and that these estimates are the basis for the financial statements submitted under these Rules. If the estimated and documented liability has not met the requirements of Rule 1300.77.2 in any way, the statement shall be accompanied by a report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

~~Option 1:~~

(4) (A) A statement as to whether or not the organization (i) has at all times during the quarter maintained a positive tangible net equity ("TNE"), as defined in Rule 1300.76(e); and

(ii) has at all times during the quarter maintained a positive level of working capital, calculated in a manner consistent with generally accepted accounting principles (GAAP). If either the required TNE or the required working capital has ~~have~~ not been maintained at all times, the statement shall be accompanied by a report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.

(B) The organization may reduce its liabilities for purposes of calculating its tangible net equity and working capital in a manner allowed by Health and Safety Code Section 1375.4(b)(1)(B). For purposes of Health and Safety Code Section 1375.4(b)(1)(B), a sponsoring organization shall have a tangible net equity of at least twice the total of all amounts that it has guaranteed to all persons or entities, or a tangible net equity in an amount approved by the Director of the Department of Managed Health Care.

~~***Option 2:***~~

~~(4) (A) A statement as to whether or not the organization has at all times during the quarter maintained a positive tangible net equity ("TNE"), as defined in Rule 1300.76(e); and positive level of working capital, calculated in a manner consistent with generally accepted accounting principles (GAAP). If the required TNE or working capital have not been maintained at all times, the statement shall be accompanied by a report that describes in detail the following with respect to each deficiency: the nature of the deficiency, the reasons for the deficiency, any action taken to correct the deficiency, and any results of that action.~~

~~(B) The organization may reduce its liabilities for purposes of calculating its tangible net equity and working capital in a manner allowed by Health and Safety Code Section 1375.4(b)(1)(B). For purposes of Health and Safety Code Section 1375.4(b)(1)(B), a sponsoring~~

~~organization shall have a tangible net equity of at least twice the total of all amounts that it has guaranteed to all persons or entities, or a tangible net equity in an amount approved by the Director of the Department of Managed Health Care.~~

~~(C) For purposes of subparagraph 4(A), "at all times" means, at a minimum, on a consistent basis, and at all times when any internal financial statement is generated or produced.~~

(5) A written verification attached to each report made under paragraphs (1), (2), (3) and (4) of this subsection stating that the report is true and correct to the best knowledge and belief of ~~the~~ a principal officer of the organization, and signed by ~~the~~ a principal officer, such as the Chief Executive Officer or Chief Financial Officer.

(b) (1) If the organization served at least 10,000 lives under all risk arrangements as of December 31, 2000, ~~S~~submit to the Department of Managed Health Care or its designated agent, in a form and manner determined by the Department, not more than one hundred eighty (180 days) after the close of the organization's fiscal year beginning in year 2000, and, regardless of the number of lives served under all risk arrangements, submit to the Department not more than one hundred twenty (120) days after the close of the organization's ~~each~~ fiscal year beginning on or after January 1, 2001, and not more than one hundred twenty (120) days after the close of each of the organization's subsequent fiscal ~~in~~ years, ~~2001 and following years~~, an audit report prepared by an independent certified public accountant in accordance with generally accepted auditing standards (or governmental auditing standards in the case of a public entity), containing all of the following:

(A ~~1~~) Audited f~~F~~inancial statements (including at least a balance sheet, an income statement, a statement of cash flows, and footnote disclosures), or comparable financial

statements in the case of a nonprofit entity, for the immediately preceding fiscal year, prepared by the independent certified public accountant in accordance with generally accepted accounting principles (GAAP). For purposes of determining the independence of the certified public accountant, the regulations of the California State Board of Accountancy (Division 1, Sections 1 through 99.2, Title 16, California Code of Regulations), shall apply.

(B ~~2~~) An opinion of the accountant indicating that the financial statements submitted to the Department present fairly, in all material respects, the financial position of the organization, and that the financial statements were prepared in accordance with generally accepted accounting principles (GAAP). ~~With this opinion of the accountant, there must be included a redacted copy of the audit management letter including all portions of the management letter related to the organization's financial solvency.~~

(2) If the organization served fewer than 10,000 lives under all risk arrangements as of December 31, 2000, submit to the Department of Managed Health Care or its designated agent, in a form and manner determined by the Department, not more than one hundred eighty (180 days) after the close of the organization's fiscal year beginning in year 2000, an accountant's report on a review including a statement of limited assurance that the financial statements are in accordance with generally accepted accounting principles (GAAP) or some other comprehensive basis of accounting. The accountant's report on a review must cover all of the following:

(A) Reviewed financial statements (including at least a balance sheet, an income statement, a statement of cash flows, and footnote disclosures), or comparable financial statements in the case of a nonprofit entity, for the immediately preceding fiscal year, prepared by the independent certified public accountant in accordance with generally accepted accounting

principles (GAAP) or some other comprehensive basis of accounting. For purposes of determining the independence of the certified public accountant, the regulations of the California State Board of Accountancy (Division 1, Sections 1 through 99.2, Title 16, California Code of Regulations), shall apply.

(B) An opinion of the accountant indicating limited assurance that the financial statements submitted to the Department were prepared in accordance with generally accepted accounting principles (GAAP) or some other comprehensive basis of accounting.

(~~3~~ c) Submit to the Department of Managed Health Care or its designated agent, in a form and manner to be determined by the Department, ~~A~~ a "Statement of Organization," to be filed with the organization's initial quarterly filing ~~on or before May 15, 2001~~, and with each ~~subsequent~~ annual filing made in subsequent years, which shall include the following information, as of December 31 of each calendar year prior to the filing:

(1~~A~~) Name and Address of the ~~Risk-Bearing~~ Organization;

(2~~B~~) Contact Person, with ~~Name,~~ Title, Address, Phone, Fax, and e-mail address;

(3~~C~~) A list of ~~A~~all Health Plans with which the ~~risk-bearing~~ organization has ~~contracts~~ risk arrangements;

(4~~D~~) Whether the Organization is an Independent Practice Association (IPA), Medical Group, Foundation, other entity, or some combination ~~or both~~;

(5) Whether the Organization is a professional corporation, partnership, not-for-profit corporation, sole proprietor, or other form of business;

(6~~E~~) A matrix listing the major categories of primary care, cardiology, orthopedics, ophthalmology, oncology, and radiology, and next to each listed category in the matrix, a disclosure of the compensation model (salary, fee-for-service, capitation, other) used by the

organization to compensate the majority of providers of that category of care; ~~All other medical providers, including hospitals, pharmacy companies, laboratories, practitioners, etc., with which the risk-bearing organization has contracts;~~

(7~~F~~) An approximation of the Number of Enrollees served by the Organization under a risk arrangement, pursuant to a list of ranges developed by the Department;

(8 ~~G~~) Any Management Services Organization (MSO) that the ~~risk-bearing~~ organization contracts with for administrative services;

(9~~H~~) ~~List of Primary Care~~ Number of in-network contracted Physicians in the organization ~~with name, address, phone, and fax for each~~;

(10~~I~~) ~~Description of Geographic Area Served by the risk-bearing organization~~ Disclosure by California County or Counties of the Organization's primary service area (excluding out-of-area tertiary facilities and providers);

~~(J) List of Affiliated Hospitals, with name, address, phone, and fax for each;~~

(11~~K~~) Any other information which the Director deems reasonable and necessary.

(~~c~~ d) Notify the Department of Managed Health Care or its designated agent no later than five (5) business days from discovering that the organization has experienced any event which ~~might~~ would materially alter its financial situation, or threaten its solvency. ~~Examples might include, but are not limited to, the loss of enrollees represented by a major employer; a substantial overpayment by a health plan which is re-claimed by that health plan; and any other event which would materially alter the organization's financial situation.~~

(~~d~~ e) Permit the Department of Managed Health Care or its designated agent to make any examination that it deems reasonable and necessary to implement Section 1375.4 ~~determine~~

~~whether the organization is meeting the criteria~~ of the Health and Safety Code ~~Section 1375.4(b)(1)(A)(i), (ii), (iii), and (iv)~~, and provide to the Department, upon request, any books or records that the Department deems relevant for inspection and copying.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

1300.75.4.3. Plan Reporting.

(a) Every plan that contracts with an ~~risk-bearing~~ organization shall, by May 15, ~~April 1~~, 2001, for the first ~~fourth~~ quarter of calendar year 2001, ~~2000,~~ and not more than forty-five (45) days after the close of each subsequent quarter, submit a report to the Director, in a form and manner determined by the Department of Managed Health Care, ~~containing a~~ listing ~~of~~ all its contracting organizations including their names, addresses, contact persons, ~~and~~ telephone numbers, and number of lives contracted for. ~~describing all risk arrangements with each organization in a manner that enables the Director to determine the type and amount of financial risk assumed by each organization including, at a minimum, the following information for each and every risk arrangement:~~

~~(1) The nature of the risk arrangement.~~

~~(2) The purpose of the risk arrangement.~~

~~(3) The method for determining each and every amount (including expenses and income) allocated to the organization and to the plan under the risk-sharing arrangement.~~

~~(4) A separate explanation of the method of calculating each and every amount allocated to the organization and to the plan for the provision of any pharmacy services under the risk arrangement.~~

~~(5) The time period for the risk arrangement.~~

~~(6) Each and every amount allocated to the organization and to the plan under the risk arrangement.~~

~~(7) Any problem experienced by either the plan or the organization with respect to the risk arrangement and, for each problem, a description of any action taken to correct that problem together with an explanation of the results of that action.~~

(b) For the quarterly report due May 15, 2001, and for the report due within 45 days after the close of the first quarter of each subsequent year (i.e., an annual reporting period), every plan must provide the following information for each organization with which the plan has a risk arrangement:

(1) For the plan's commercial, Medicare+Choice, and Medi-Cal product lines, please disclose, in a separate matrix for each product line, the allocation of risk assumption between the plan, the organization, and the facility for each of the following services:

(A) hospital inpatient;

(B) hospital outpatient;

(C) primary care;

(D) specialty care;

(E) pharmacy; and

(F) ancillary care.

For each of the plan's commercial, Medicare+Choice, and Medi-Cal product lines, please disclose the number of covered lives.

(2) Please disclose whether the plan provides stop-loss insurance to the organization, and if so, the nature of any and all stop-loss arrangements.

(c ~~b~~) ~~Each quarterly report shall specify the plan's name, the quarter and date of report. In addition each quarterly report shall be signed by a person authorized to do so by the plan, verified, and filed along with two copies of the report, in the Department's Sacramento Office to the attention of the Health Plan Filing Clerk. The quarterly report need not be filed as an amendment to the plan application.~~ Each report or matrix submitted to the Department shall include a written verification stating that the report or matrix is true and correct to the best knowledge and belief of a principal officer of the plan, and signed by a principal officer, such as the Chief Executive Officer or Chief Financial Officer.

(d ~~c~~) Upon request, the plan shall provide any additional information that the Director may from time to time require to understand the type, amount, or appropriateness, of the financial risk assumed by the plan's organizations.

(e ~~d~~) Every plan that contracts with an organization shall have adequate procedures in place to ensure that the plan notifies the Department of Managed Health Care or its designated agent no later than five (5) business days from discovering that any of its organizations experienced any event which ~~might~~ would materially alter the organization's financial situation, or threaten its solvency. ~~Examples might include, but are not limited to, the loss of enrollees represented by a major employer; a substantial overpayment by a health plan which is re-claimed by that health plan; and any other event which would materially alter the organization's financial situation.~~

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

1300.75.4.4. Confidentiality.

The Director shall provide for the confidentiality of financial and other records to be produced, disclosed, or otherwise made available pursuant to Health and Safety Code Section 1375.4, and to these regulations, unless the Director determines otherwise.

NOTE: Authority cited: Sections 1344, 1375.4(b)(7), and 1375.4, Health and Safety Code. Reference: Sections 1375.4 and 1375.4(b)(7), Health and Safety Code.

1300.75.4.5. Plan Compliance.

Any failure of a plan to comply with the requirements of Section 1375.4 of the Code and any rules of this subarticle shall constitute grounds for disciplinary action against the plan. The Director may seek and employ any combination of remedies and enforcement procedures provided under the Act, to enforce Section 1375.4 of the Code and this subarticle.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Section 1375.4, Health and Safety Code.

1300.75.4.6. Department Costs.

The Department's cost incurred in the administration of Section 1347.15 and 1375.4 of the Code shall come from amounts paid by plans, except specialized plans, pursuant to Section 1356 of the Code.

NOTE: Authority cited: Sections 1344 and 1375.4, Health and Safety Code. Reference: Sections 1374.15, 1356 and 1375.4, Health and Safety Code.